STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155221	A. BUILDING 00 B. WING	05/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS GARDENS HEALTH CENTER	1120 EAST DAVIS DRIVE TERRE HAUTE, IN47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 23-27; and 31, 2011 Facility number: 000126 Provider number: 155221 AIM number: 100266400 Survey team: Teresa Buske RN -TC Mary Weyls RN Laura Brashear RN Census bed type: SNF/NF: 62 Residential: 34 Total: 96 Census payor type: Medicare: 12 Medicaid: 26 Other: 58 Total: 96 Sample: 15 Residential sample: 4 Supplemental sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	By submitting this document we are not admitting the truth or accuracy of any specific findings or allegations. This submission is made solely pursuant to our regulatory obligations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 6/5/11 Cathy Emswiller RN			
F0225 SS=E	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on interview and record review, the facility failed to report to the Administrator and DON immediately and thoroughly investigate allegations of mistreatment for 5 of 15 residents reviewed in a sample of 15. [Residents #63, #3, #5, #48, #42] Findings include: 1. On 5/26/11 at 12:20 p.m. the facility's compliance/grievance log was reviewed. A form titled "Report of Grievance or Complaint," with received date of 11/8/10 was noted of "Name of person making complaint [name] [Resident #63] with the following documentation: "Concern report to Social Services staff- [names] Name and title of person completing report [name] SW." The description of concern was noted of: "States that CNA on nights [CNA #14] made her feel like she was too much trouble, was distant and noncaring when she came in to provide care-states that told her when answering a light that I can put you on the bedpan-but I have to go to lunch-left call unattended long periods of time (1 hour) would have to wet the bed. Witnessed by [names of social service and leisure service workers."] An additional note on the form included "Res [resident] was tearful during interview when began thinking of the CNA. Stated she "tensed up" before	F0225	What corrective action(s) will be accomplished for those residents found to have been been affected by the deficient practice:Resident #65 is no longer at the facility. Residents #3, 48, 42, and 5 have had no further incidents. CNAs #3 and #14 are no longer employed at the facility. The private sitter for #48 no longer cares for the resident. LPN #19 was suspended for investigation of allegation of abuse on 5/27/2011. Investigation included interviewing resident #42, interviewing other residents, interviewing coworkers, and notifying the Indiana Department of Health. Based on the investigation outcome the employee returned to work; the resident and the Indiana Department of Health were notified of the outcome.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents have the potential to be effected by this deficient practice. All staff will be educated on the community's policy and procedure associated with abuse/allegations of abuse identification and timely reporting with emphasis on: the need to report to the supervisor, DON and the administrator with nights, weekends or holidays not being an exception; the need for the accused individual to be removed from the community	06/29/2011

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	CNA came in." Documentation on a copy of the Report of Grievance or Complaint form indicated the complaint was reported to the former DON on 11/8/10 for follow up. The investigation included interview of CNA #16 and CNA #14. The written statement from CNA #16 included, but was not limited to "A few days after the resident in room [number] was admitted she started asking me what was wrong with the CNA on night shift. ...she stated that the CNA [#14] was grouchy and acted like she was always mad about something. The resident then started to act nervous and she asked me if I would put a brief on her. I asked the resident why she wanted it on if she uses the bedpan throughout the night. The resident then stated that she tries to use the bedpan but the CNA [#14] takes too long to answer her call light, it then results in her wetting the bed. The resident appeared upset while talking about the situation saying that the CNA [#14] gets mad at her when she has to change the bed. The resident kept asking me why the CNA [#14] was treating her that way. The next day, the resident told me that she turned her call light on around 10:20 p.m. the night before to be taken off the bedpan. She stated that the CNA [#14] came into her room and asked her in a hateful tone what she needed. When the		immediately; thorough investigation of the situation with documented interviews with all staff (on all shifts) who have had contact with the resident during the alleged event; notification of the responsible party and MD in a timely manner; and, abuse/allegations of abuse by visitors, family members, or anyone in contact with a resident mandates the same reporting requirements and follow up as with community employees. All staff will be educated on the grievance/concern policy and procedure with need for follow up in a timely manner. The Social Service Director will bring any new complaints to daily stand-up meeting and will work, along with the administrator and other management, to immediately identify and act on any complaints that may involve abuse or possible abuse. The community will provide information to the residents of the recommended home health agencies when the resident is in need of or desires private duty assistance. If the resident or their responsible party chooses not to utilize a recommended agency then the resident will be provided with a copy of the community Personal Service Provider Policy. Personal service providers will be expected to sign in upon arrival and out upon departure and will provide acknowledgement of the community's policy and procedure	

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	resident told her that she was on the bedpan the CNA [#14] started complaining to resident telling her that she did not know why I could not have got her off the bedpan myself because all I was doing was sitting on my butt doing nothing. Resident then asked me, why CNA [#14] hated me. I told her that I did not know. The resident then asked me if she should use the bedpan before CNA [#14] arrives. Resident appeared to be shaken up as I finished getting her ready for bed. I told resident that the CNA [#14] would not be working in the health center on that day. Resident replied by stating "GOOD", and appeared to calm down." A document titled "Counseling/Disciplinary Action Form," dated 11/11/10, regarding CNA #14, completed by the former DON on 11/11/10, included an occurrence or violation of unsatisfactory work performance not answering call light timely-resident left on bedpan and went to break making resident feel uncomfortable and afraid to ask for assistance from this aide. Aide comes across as rude and intimidating. Plan of action: Aide suspended times 3 days for investigation upon findings. Aide to apologize to resident for any misunderstanding between them." Supervisor Comments:		associated with abuse/allegations of abuse and timely reporting.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:Education will be provided to all staff at the time of hire on abuse/allegation of abuse identification and reporting. This education will be presented at all-staff meetings at least every six months. Education will be provided to all staff at the time of hire on the grievance/concern policy and procedure with need for follow up in a timely manner. This education will be presented at all-staff meetings at least every six months. The Social Service Director will bring any new complaints to daily stand-up meeting and will work, along with the administrator and other management, to immediately identify and act on any complaints that may involve abuse or possible abuse. All situations of abuse/allegations of abuse will be immediately investigated by community mangement including the administrator. The Department of Health will be notified of the investigation's onset and outcome. The MD and responsible party and/or resident will be notified of the investigation and its outcome. Social Service will review the status of concerns and grievances including new concerns and grievances during the daily stand-up meeting. Each	

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	"Any further complaints or occurrences will result in further disciplinary action-up to and including termination." The Administrator was interviewed on 5/27/11 at 9:40 a.m. The Administrator indicated he was made aware of the allegation on 11/8/10. The Administrator indicated based on what the former DON told him thought it was more of a care issue. CNA #14's employee file was reviewed on 5/27/11 at 2:00 p.m. A written document from RN #15 was noted dated 10/30/10 to the former DON. "[Name] Resident #65 in Room [number] told me today that she dreaded the "nights" because the CNA [description of CNA #14] would be taking care of her. Resident #65 stated that everyone has been wonderful except for this one night CNA. This CNA does not answer her call light and handles her roughly, acting like it does not matter that she has to use the bathroom or that she is in pain. She also said that she has urinated on herself several times because the call light was not answered. She was very relieved when I told her this is the weekend and a different CNA would be here tonight. A second note, written on the same document, dated 10/31/10 indicated Resident #63 said last night was much better and the CNA was wonderful.		grievance and concern will remain on the agenda until resolved. Resolutions will be communicated to the resident or responsible party.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:Audits will be conducted in regards to abuse training and reporting and all aspects of abuse prohibition by the DON and administrator or their designee(s). These audits will be done at least monthly and will include resident and family interviews, employee interviews, and records review. Results will be presented at the community's Quality Assurance meeting for at least three months for evaluation and recommendations. Continuation of audits will be dependent on audit outcomes.	

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	She is feeling better this a.m. Maybe a change could be made so she will not dread the "nights." The report was signed by RN # 16. Any documentation of an investigation or reporting of the allegation to the Administrator was lacking. On 5/27/10 at 4:30 p.m., the Administrator was interviewed. The Administrator indicated he had not been made aware of the allegation, and was not aware of any investigation being done. A copy of CNA #14's time card for the period of 10/30/10 to 11/30/10, provided by the DON on 5/31/11 at 12:50 p.m. documented the CNA worked on 11/1-4/10; 11/11-12/10; 11/15-19/10; 11/22-24/10; 11/25-26/10; 11/30/10. Documentation in CNA #14's employee file indicated the CNA resigned in April, 2011. Resident #63's closed clinical record was reviewed on 5/26/11 at 10:15 a.m. An admission date was noted of 10/26/10. The resident's diagnoses included, but were not limited to, multiple traumatic injuries [fractures] from a motor vehicle accident. An admission nursing assessment, completed on 10/26/10 indicated the resident was alert and oriented,			

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	communicated without difficulties, required assistance of one for toileting, and one or two with dressing and bathing. The assessment indicated the resident utilized a brace and wheelchair for mobility, was continent of urine and utilized a bedpan. 2. A document titled "Facility Incident Reporting Form," provided by the Administrator on 5/25/11 at 12:50 p.m. documented CNA #4 reported to the supervisor she heard CNA #20 tell Resident #3 to "shut up." The report documented indicated the Acting DON was notified and she and LPN #21 met with CNA #20 and suspended her pending an investigation. A written report of the investigation indicated four residents were interviewed. All four residents indicated there was a CNA that was rude, and should not talk to people the way she does, but did not identify the staff member. Interviews of other staff members were not included in the investigation. The Administrator was interviewed on 5/25/11 at 12:50 p.m. The Administrator indicated other staff members were not interviewed and as far as the investigation the residents' comments were not regarded as abusive.			

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3. Interview of CNA #3 on 5/25/11 at 4:25 a.m. indicated RN #27 had talked to a former CNA #14 during the night shift regarding Resident # 5. CNA #3 indicated Resident #5 had called to the nursing station from her room one night with complaint of CNA #14 stating she would not come down and place the resident on the bed pan every time she turned the light on. CNA #3 stated that RN #27 talked to CNA #14 and told her she would answer the resident's call light and be "nice" to her. CNA #3 indicated Resident #5 was alert and oriented.

Interview of RN #27 on 5/27/11 at 6:05 p.m. indicated Resident #5 had contacted him and indicated CNA #14 was "cross with me." RN #27 indicated he had talked to CNA #14 and told her to be "more kind." The RN indicated the incident was probably occurred last fall. The RN also stated "I was afraid it will come back to me if I said too much." The RN indicated this was not reported to the Administrator or the Director of Nursing at the time of the incident.

During interview of resident #5 on 5/24/11 at 2:55 p.m., the resident indicated CNA # 14 was nasty some times and that she had reported the CNA to the

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	nurses. Interview of the Administrator on 5/27/11 at 4:30 p.m. indicated he was unaware of concerns regarding Resident #5 with CNA #14. 4. Review of the clinical record of Resident # 48 on 5/25/11 at 1:05 p.m. indicated a nursing note dated 2/27/11 at 6:15 a.m. of "CNA reported to this nurse that resident sitter [sic] was verbally rude et [and] handled resident rather roughly et [and] that she didn't know what to do. Advised CNA she needed to call DON [Director of Nursing (not current DON)] et report it ASAP [as soon as possible]. Asked if sitter still here CNA states yes. This nurse went to doorway of room sitter gathering her belongings. This nurse stayed in immediate area. 0630 Sitter left resident room CNA on phone c [with] DON this nurse checked resident [no] injuries noted [no] c/o [complaint of] problems or pain from resident . Per DON have CNA doc [document] et this nurse will call family et report incident. 0659 Called POA [name] et reported incident et advised resident is fine has [no] injuries or ill effects...1050 Niece [name] returned call...per family she [sitter] is not to have any further contact c [with] resident . DON and staff advised."			

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	The most recent Minimum Data Set (MDS) assessment dated 3/7/11 indicated the resident was cognitively impaired. Interview of Administrator on 5/26/11 at 1:20 p.m. indicated he was unaware of incident. The Administrator also indicated that the facility does not arrange for the sitters and that the families of the resident's arrange for the sitters. Interview of current DON on 5/26/11 at 3 p.m. indicated an investigation had not been completed regarding the incident i.e. talking to staff, or other residents. 5. Interview of Resident # 42 on 5/24/11 at 11 a.m. indicated that 1-2 months ago the night nurse LPN #19 had hurt her feelings due to a statement she made. The resident stated she had stated to the nurse that "she was sick and tired of being here" and that LPN #19 had stated "you aren't the only one who is tired of you being here." The resident stated she had talked to "someone" in administration about it but could not remember specific person. The resident stated she had no concerns currently with LPN #19. Interview of the Administrator on 5/26/11 at 3:45 p.m. indicated he was unaware of any concerns with Resident #42 and LPN #19.			

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	Review of investigation dated 5/27/11 indicated Resident #42 stated LPN #19 had hurt her feelings by saying she was tired of her too. The investigation was not thorough in that the investigation included interview with Resident #42 and LPN #19 only. 3.1-28(c) 3.1-28(d)			
F0226 SS=E	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement policies and procedures for 3 of 4 allegations of abuse reviewed in that immediate reporting of allegations to the Administrator,and to the state agency and all other agencies as required, thorough investigations and provision of protection pending an investigation were not done. [Residents #63, #3, #5, #48, #42] Findings include: 1. On 5/26/11 at 12:20 p.m. the facility's compliance/grievance log was reviewed. A form titled "Report of Grievance or	F0226	What corrective action(s) will be accomplished for those residents found to have been been affected by the deficient practice:Resident #65 is no longer at the facility. Residents #3, 48, 42, and 5 have had no further incidents. CNAs #3 and #14 are no longer employed at the facility. The private sitter for #48 no longer cares for the resident. LPN #19 was suspended for investigation of allegation of abuse on 5/27/2011. Investigation included interviewing resident #42, interviewing other residents, interviewing coworkers, and notifying the Indiana Department of Health. Based on the investigation's outcome the	06/29/2011

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	Complaint," with received date of 11/8/10 was noted of "Name of person making complaint [name] [Resident #63] with the following documentation: "Concern report to Social Services staff- [names] Name and title of person completing report [name] SW." The description of concern was noted of: "States that CNA on nights [CNA #14] made her feel like she was too much trouble, was distant and noncaring when she came in to provide care-states that told her when answering a light that I can put you on the bedpan-but I have to go to lunch-left call unattended long periods of time (1 hour) would have to wet the bed. Witnessed by [names of social service and leisure service workers."] An additional note on the form included "Res [resident] was tearful during interview when began thinking of the CNA. Stated she "tensed up" before CNA came in." Documentation on a copy of the Report of Grievance or Complaint form indicated the complaint was reported to the former DON on 11/8/10 for follow up. The investigation included interview of CNA #16 and CNA #14. The written statement from CNA #16 included, but was not limited to "A few days after the resident in room [number] was admitted she started asking me what was wrong with the CNA on night shift. ...she stated that the CNA		employee returned to work; the resident and the Indiana Department of Health were notified of the outcome.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents have the potential to be effected by this deficient practice. All staff will be educated on the community's policy and procedure associated with abuse/allegations of abuse identification and timely reporting with emphasis on: the need to report to the supervisor, DON and the administrator with nights, weekends or holidays not being an exception; the need for the accused individual to be removed from the community immediately; thorough investigation of the situation with documented interviews with all staff (on all shifts) who have had contact with the resident during the alleged event; notification of the responsible party and MD in a timely manner; and, abuse/allegations of abuse by visitors, family members, or anyone in contact with a resident mandates the same reporting requirements and follow up as with community employees. All staff will be educated on the grievance/concern policy and procedure with need for follow up in a timely manner. The Social Service Director will bring any new complaints to daily stand-up	

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	[#14] was grouchy and acted like she was always mad about something. The resident then started to act nervous and she asked me if I would put a brief on her. I asked the resident why she wanted it on if she uses the bedpan throughout the night. The resident then stated that she tries to use the bedpan but the CNA [#14] takes too long to answer her call light, it then results in her wetting the bed. The resident appeared upset while talking about the situation saying that the CNA [#14] gets mad at her when she has to change the bed. The resident kept asking me why the CNA [#14] was treating her that way. The next day, the resident told me that she turned her call light on around 10:20 p.m. the night before to be taken off the bedpan. She stated that the CNA [#14] came into her room and asked her in a hateful tone what she needed. When the resident told her that she was on the bedpan the CNA [#14] started complaining to resident telling her that she did not know why I could not have got her off the bedpan myself because all I was doing was sitting on my butt doing nothing. Resident then asked me, why CNA [#14] hated me. I told her that I did not know. The resident then asked me if she should use the bedpan before CNA [#14] arrives. Resident appeared to be shaken up as I finished getting her ready for bed. I told resident that the CNA		meeting and will work, along with the administrator and other management, to immediately identify and act on complaints that may involve abuse or possible abuse.The community will provide information to the residents of the recommended home health agencies when the resident is in need of or desires private duty assistance. If the resident or their responsible party chooses not to utilize a recommended agency then the resident will be provided with a copy of the community Personal Service Provider Policy. Personal service providers will be expected to sign in upon arrival and out upon departure and will provide acknowledgement of the community's policy and procedure associated with abuse/allegations of abuse and timely reporting.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:Education will be provided to all staff at the time of hire on abuse/allegation of abuse identification and reporting. This education will be presented at all-staff meetings at least every six months. Education will be provided to all staff at the time of hire on the grievance/concern policy and procedure with need for follow up in a timely manner. This education will be presented at all-staff meetings at least every six months. The Social Service	

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	[#14] would not be working in the health center on that day. Resident replied by stating "GOOD", and appeared to calm down." A document titled "Counseling/Disciplinary Action Form," dated 11/11/10, regarding CNA #14, completed by the former DON on 11/11/10, included an occurrence or violation of unsatisfactory work performance not answering call light timely-resident left on bedpan and went to break making resident feel uncomfortable and afraid to ask for assistance from this aide. Aide comes across as rude and intimidating. Plan of action: Aide suspended times 3 days for investigation upon findings. Aide to apologize to resident for any misunderstanding between them." Supervisor Comments: "Any further complaints or occurrences will result in further disciplinary action-up to and including termination." The Administrator was interviewed on 5/27/11 at 9:40 a.m. The Administrator indicated he was made aware of the allegation on 11/8/10. The Administrator indicated based on what the former DON told him thought it was more of a care issue. CNA #14's employee file was reviewed on		Director will bring any new complaints to daily stand-up meeting and will work, along with the administrator and other management, to immediately identify and act on any complaints that may involve abuse or possible abuse.All situations of abuse/allegations of abuse will be immediately investigated by community mangement including the administrator. The Department of Health will be notified of the investigation's onset and outcome. The MD and responsible party and/or resident will be notified of the investigation and its outcome. Social Service will review the status of concerns and grievances including new concerns and grievances during the daily stand-up meeting. Each grievance and concern will remain on the agenda until resolved. Resolutions will be communicated to the resident or responsible party.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:Audits will be conducted in regards to abuse training and reporting and all aspects of abuse prohibition by the DON and administrator or their designee(s). These audits will be done at least monthly and will include resident and family interviews, employee interviews, and records review. Results will be presented at the community's Quality Assurance meeting for at least three months for evaluation	

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	5/27/11 at 2:00 p.m. A written document from RN #15 was noted dated 10/30/10 to the former DON. "[Name] Resident #63 in Room [number] told me today that she dreaded the "nights" because the CNA [description of CNA #14] would be taking care of her. Resident #63 stated that everyone has been wonderful except for this one night CNA. This CNA does not answer her call light and handles her roughly, acting like it does not matter that she has to use the bathroom or that she is in pain. She also said that she has urinated on herself several times because the call light was not answered. She was very relieved when I told her this is the weekend and a different CNA would be here tonight. A second note, written on the same document, dated 10/31/10 indicated Resident #63 said last night was much better and the CNA was wonderful. She is feeling better this a.m. Maybe a change could be made so she will not dread the "nights." The report was signed by RN # 16. Any documentation of an investigation or reporting of the allegation to the Administrator was lacking. On 5/27/10 at 4:30 p.m., the Administrator was interviewed. The Administrator indicated he had not been made aware of the allegation, and was not aware of any investigation being done. A copy of CNA #14's time card for the		and recommendations. Continuation of audits will be dependent on audit outcomes.	

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	period of 10/30/10 to 11/30/10, provided by the DON on 5/31/11 at 12:50 p.m. documented the CNA worked on 11/1-4/10; 11/11-12/10; 11/15-19/10; 11/22-24/10; 11/25-26/10; 11/30/10. Documentation in CNA #14's employee file indicated the CNA resigned in April, 2011. Resident #63's closed clinical record was reviewed on 5/26/11 at 10:15 a.m. An admission date was noted of 10/26/10. The resident's diagnoses included, but were not limited to, multiple traumatic injuries [fractures] from a motor vehicle accident. An admission nursing assessment, completed on 10/26/10 indicated the resident was alert and oriented, communicated without difficulties, required assistance of one for toileting, and one or two with dressing and bathing. The assessment indicated the resident utilized a brace and wheelchair for mobility, was continent of urine and utilized a bedpan. 2. A document titled "Facility Incident Reporting Form," provided by the Administrator on 5/25/11 at 12:50 p.m. documented CNA #4 reported to the supervisor she heard CNA #20 tell			

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	Resident #3 to "shut up." The report documented indicated the Acting DON was notified and she and LPN #21 met with CNA #20 and suspended her pending an investigation. A written report of the investigation indicated four residents were interviewed. All four residents indicated there was a CNA that was rude, and should not talk to people the way she does, but did not identify the staff member. Interviews of other staff members were not included in the investigation. The Administrator was interviewed on 5/25/11 at 12:50 p.m. The Administrator indicated other staff members were not interviewed and as far as the investigation the residents' comments were not regarded as abusive. 3. Interview of CNA #3 on 5/25/11 at 4:25 a.m. indicated RN #27 had talked to a former CNA #14 during the night shift regarding Resident # 5. CNA #3 indicated Resident #5 had called to the nursing station from her room one night with complaint of CNA #14 stating she would not come down and place the resident on the bed pan every time she turned the light on. CNA #3 stated that RN #27 talked to CNA #14 and told her she would answer			

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	the resident's call light and be "nice" to her. CNA #3 indicated Resident #5 was alert and oriented. Interview of RN #27 on 5/27/11 at 6:05 p.m. indicated Resident #5 had contacted him and indicated CNA #14 was "cross with me." RN #27 indicated he had talked to CNA #14 and told her to be "more kind." The RN indicated the incident was probably occurred last fall. The RN also stated "I was afraid it will come back to me if I said too much." The RN indicated this was not reported to the Administrator or the Director of Nursing at the time of the incident. During interview of resident #5 on 5/24/11 at 2:55 p.m., the resident indicated CNA #14 was nasty some times and that she had reported the CNA to the nurses. Interview of the Administrator on 5/27/11 at 4:30 p.m. indicated he was unaware of concerns regarding Resident #5 with CNA #14. 4. Review of the clinical record of Resident # 48 on 5/25/11 at 1:05 p.m. indicated a nursing note dated 2/27/11 at 6:15 a.m. of "CNA reported to this nurse that resident sitter [sic] was verbally rude et [and] handled resident rather roughly et [and] that she didn't know what to do. Advised CNA she needed to call DON [Director of Nursing			

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	(not current DON)] et report it ASAP [as soon as possible]. Asked if sitter still here CNA states yes. This nurse went to doorway of room sitter gathering her belongings. This nurse stayed in immediate area. 0630 Sitter left resident room CNA on phone c [with] DON this nurse checked resident [no] injuries noted [no] c/o [complaint of] problems or pain from resident . Per DON have CNA doc [document] et this nurse will call family et report incident. 0659 Called POA [name] et reported incident et advised resident is fine has [no] injuries or ill effects...1050 Niece [name] returned call...per family she [sitter] is not to have any further contact c [with] resident . DON and staff advised." The most recent Minimum Data Set (MDS) assessment dated 3/7/11 indicated the resident was cognitively impaired. Interview of Administrator on 5/26/11 at 1:20 p.m. indicated he was unaware of incident. The Administrator also indicated that the facility does not arrange for the sitters and that the families of the resident's arrange for the sitters. Interview of current DON on 5/26/11 at 3 p.m. indicated an investigation had not been completed regarding the incident i.e. talking to staff, or other residents. 5. Interview of Resident # 42 on 5/24/11 at 11 a.m. indicated that 1-2 months ago the night nurse LPN #19 had hurt her feelings due to a statement she made. The resident stated she had stated to the nurse that "she was sick and tired of being here" and that LPN #19 had stated "you aren't the only one who is tired of you being here." The resident stated she had talked to "someone" in administration about it but could not remember			

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	specific person. The resident stated she had no concerns currently with LPN #19. Interview of the Administrator on 5/26/11 at 3:45 p.m. indicated he was unaware of any concerns with Resident #42 and LPN #19. Review of investigation dated 5/27/11 indicated Resident #42 stated LPN #19 had hurt her feelings by saying she was tired of her too. The investigation was not thorough in that the investigation included interview with Resident #42 and LPN #19 only. Review of facility's current policy and procedure titled "Reportable Unusual Occurrences" dated 1/25/2006 on indicated "the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency...ABUSE- physical, sexual, verbal and/or mental (known and/or alleged) ..." Review of facility's current policy and procedure titled "Abuse Investigations" dated 4/2010 on 5/27/11 at 4 p.m. indicated "All reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management...3. The individual conducting the investigation will, as a minimum : ...b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person (s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); ...g. Interview staff members (on all shifts) who have had contact with			

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	the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and visitors; i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up the alleged incident..." **3.1-28(a)**			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop a comprehensive care plan for 1 of 1 residents reviewed, receiving bruises	F0279	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #28 was assessed by her MD and	06/29/2011

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	during transfers in a sample of 15 in that a plan of care identified the resident as requiring extensive assistance, but failed to identify specific approaches to be utilized during the physical transfers. (Resident #28) Findings include: During initial tour on 5/23/11 at 11:15 a.m., the DON indicated resident #28 required extensive assist for toileting with staff assistance and was alert/oriented. Resident #28's clinical record was reviewed on 5/25/11 at 12:05 p.m. On 5/12/11 at 2 p.m., nurses notes indicated "POA (power of attorney).... notified of bruising on buttock pt [patient] states its from where she sits on commode, instructed pt to try to seat (sic) down easier." On 5/16/11 at 1:30 p.m., nurses notes indicated "bruise to bil (bilateral) buttock cont (continue) fading resident frequently flops in chair et [and] commode freq (frequently) observed self transferring or observed attempting to." A quarterly Minimum Data Set (MDS) assessment, dated 12/14/11, indicated the resident required extensive assist of one		found to have no serious injury related to this deficient practice The resident's care plan was reviewed and updated to include a plan for transfers with extensive assist of one with gait belt and use of hand rails and toilet riser as applicable. Orders for physical and occupational therapy were obtained for Resident #28 to focus on transfers, wheelchair management, and therapeutic activities.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents receiving assistance with transfers have the potential to be affected by this deficient practice. Transfer instructions for each applicable resident will be reviewed and revised as needed by the Director of Nursing or her designee so that they are specific as to number of staff needed to assist. In addition, nursing staff and rehabilitation staff will work together to assess transfer needs according to resident's preference for assistance; resident's mobility and degree of dependency; resident's size; resident's weight-bearing ability; resident's cognitive status; and whether the resident is usually cooperative with staff. It will then be verified that written instructions to CNAs and the plan of care properly reflect transfer instructions. All CNAs will have a skill verification completed regarding transfer	

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	person for transfers. An annual Minimum Data Set (MDS) assessment, dated 3/2/11, indicated the resident required extensive assist of one person for transfers. A form titled "Care Plan Conference Summary" dated 4/6/11, identified a current concern, with a start date of 12/23/10, indicating the resident requires extensive assist with transfers. A goal was noted, indicating the resident will complete transfers with the assistance of 1-2 people/lift devices as required. An intervention was noted of "Transfer using the transfer board/lift devices." During interview on 5/26/11 at 1 p.m., the DON was unable to identify who was to decide whether one or two people would be assisting the resident with transfers, and was unable to identify type of assistive devices that should be utilized. 3.1-35(b)(1)		technique and will be trained on how to access resident-specific transfer instructions. Nursing management will do at least two observations on each shift at least two times per week for at least four weeks of CNAs completing transfers by providing assistance or extensive assistance. Deficient observations will be addressed through immediate retraining and counseling.The process of communicating and documenting change in plan of care will be discussed in daily stand-up meeting. Changes to a plan of care will be timely and appropriate and, when applicable, will also reflect in written instructions to CNAs. Licensed staff will be inserviced on the comprehensive care planning process. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:Newly hired licensed staff orientation will include training on the comprehensive care planning process. Newly hired CNAs will have a skill verification completed regarding transfer technique and will be trained on how to access resident-specific transfer instructions. Transfer instructions for each applicable resident will be reviewed and revised as necessary at least quarterly by the interdisciplinary care plan team. The instructions will be	

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			specific as to number of staff needed to assist. Nursing staff and rehabilitation staff will work together to assess transfer needs according to resident's preference for assistance; resident's mobility and degree of dependency; resident's size; resident's weight-bearing ability; resident's cognitive status; and whether the resident is usually cooperative with staff.The MDS coordinator will be responsible to assure care plans are audited for accuracy during care plan meetings. The MDS coordinator will also ensure that changes in care routine are reflected in the plan of care. The scheduler will be responsible to ensure that changes in care routine are accurately reflected in written instructions to the CNAs. Resident and/or responsible party and MD involvement in the care plan process will be encouraged. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The MDS nurse and scheduler will audit tranfer assessments, care plan changes and written instructions to CNAs, including care plan changes and written instructions to CNAs that relate to transfers. Results will be presented at the Quality Assurance meeting for at least three months for evaluation and recommendations. Continuation of audits will be dependent on audit outcomes.	

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a resident requiring assistance with transfers was receiving care to prevent bruising for 1 of 5 residents reviewed requiring extensive assist with manual transfers, in a sample of 15, in that the facility was identifying the resident was receiving bruises from sitting down to hard, and failed to establish and implement approaches to prevent the injuries. (Resident #28) Findings include: During initial tour on 5/23/11 at 11:15 a.m., the DON indicated resident #28 required extensive assist for toileting with the assistance of staff and was alert/oriented. Resident #28's clinical record was reviewed on 5/25/11 at 12:05 p.m. A nurses note, dated 12/8/10, at 2:30 p.m., indicated "Res [resident] has 5 cm (centimeter) X (by) 5 cm Bruise to [right] buttock resident denies pain et (and) has no recollection on how bruise was	F0309	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #28 was assessed by her MD and found to have no serious injury related to this deficient practice The resident's care plan was reviewed and updated to include a plan for transfers with extensive assist of one with gait belt and use of hand rails and toilet riser as applicable. Orders for physical and occupational therapy were obtained for Resident #28 to focus on transfers, wheelchair management, and therapeutic activities.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents receiving assistance with transfers have the potential to be affected by this deficient practice. Transfer instructions for each applicable resident will be reviewed and revised as needed by the Director of Nursing or her designee so that they are specific as to number of staff needed to assist. In addition, nursing staff and rehabilitation staff will work together to assess transfer needs according to resident's preference for assistance; resident's mobility	06/29/2011

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	155221	A. BUILDING 00 B. WING	05/31/2011

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	obtained... MD (medical doctor) faxed, family updated Will monitor." The next nurses note concerning the bruising was on 12/9/10 at 10:00 a.m., of "bruise on buttock slowly fading, denies pain or discomfort. No further documentation was noted in the nurses notes concerning bruising on the buttocks until 5/12/11. On 5/12/11 at 2 p.m., nurses notes indicated "POA (power of attorney).... notified of bruising on buttock pt [patient] states its from where she sits on commode, instructed pt to try to seat (sic) down easier." On 5/16/11 at 1:30 p.m., nurses notes indicated "bruise to bil (bilateral) buttock cont (continue) fading resident frequently flops in chair et [and] commode freq (frequently) observed self transferring or observed attempting to." A quarterly Minimum Data Set (MDS) assessment, dated 12/14/11, indicated the resident required extensive assist of one person for transfers. An annual Minimum Data Set (MDS) assessment, dated 3/2/11, indicated the resident required extensive assist of one person for transfers. A "Care Plan Conference Summary" dated		and degree of dependency; resident's size; resident's weight-bearing ability; resident's cognitive status; and whether the resident is usually cooperative with staff. It will then be verified that written instructions to CNAs and the plan of care properly reflect transfer instructions. All CNAs will have a skill verification completed regarding transfer technique and will be trained on how to access resident-specific transfer instructions. Nursing management will do at least two observations on each shift at least two times per week for at least four weeks of CNAs completing transfers by providing assistance or extensive assistance. Deficient observations will be addressed through immediate retraining and counseling.The process of communicating and documenting change in plan of care will be discussed in daily stand-up meeting. Changes to a plan of care will be timely and appropriate and, when applicable, will also reflect in written instructions to CNAs. Licensed staff will be inserviced on the comprehensive care planning process. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:Newly hired licensed staff orientation will include training on the comprehensive care planning process. Newly	

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	4/6/11, identified a current concern, with a start date of 12/23/10, indicating the resident requires extensive assist with transfers. A goal was noted, indicating the resident will complete transfers with the assistance of 1-2 people/lift devices as required. An intervention was noted of "Transfer using the transfer board/lift devices." A facility "Shower and Body Check" dated 5/12/11, was received from the DON on 5/26/11 at 12:05 p.m. Documentation indicated that the resident had bruises all over "butt". The form was signed by CNA #5 and RN #18. During interview of the DON on 5/26/11 at 11:45 a.m., the DON indicated CNAs do a skin check on resident's on shower days and document on shower sheets, and notify the nurse if a concern is found. The DON indicated the bruising documented in the nurses notes on 12/8/10, had documentation on an incident report. The DON indicated the incident report was filled out by LPN #19, and the documentation indicated LPN #19 felt the bruise was from the resident plopping down on the toilet, and the resident was instructed not to plop down when sitting. The DON indicated no further investigation was implemented concerning the bruising.		hired CNAs will have a skill verification completed regarding transfer technique and will be trained on how to access resident-specific transfer instructions. Transfer instructions for each applicable resident will be reviewed and revised as necessary at least quarterly by the interdisciplinary care plan team. The instructions will be specific as to number of staff needed to assist. Nursing staff and rehabilitation staff will work together to assess transfer needs according to resident's preference for assistance; resident's mobility and degree of dependency; resident's size; resident's weight-bearing ability; resident's cognitive status; and whether the resident is usually cooperative with staff.The MDS coordinator will be responsible to assure care plans are audited for accuracy during care plan meetings. The MDS coordinator will also ensure that changes in care routine are reflected in the plan of care. The scheduler will be responsible to ensure that changes in care routine are accurately reflected in written instructions to the CNAs. Resident and/or responsible party and MD involvement in the care plan process will be encouraged. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The MDS nurse and scheduler will audit tranfer assessments, care plan changes	

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	During interview on 5/26/11 at 1 p.m., the DON indicated she had spoke with CNA #'s 4 and 6. The DON indicated the CNAs indicated they transfer resident #28 with one CNA, and that the resident pulls self up with the grab bar and then the CNA places her hands around the resident's waist to help control the resident to sit down. A facility policy, dated 10/09, titled "Safe Lifting and Movement of Residents" received on, 5/26/11 at 3:35 p.m., from the administrator, documentation indicated "Nursing staff in conjunction with the rehabilitation staff, shall assess individual resident's needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: a. Resident's preferences for assistance; b. Resident's mobility (degree of dependency); c. Resident's size; d. Weight-bearing ability; e. Cognitive status; f. Whether the resident is usually cooperative with staff...." 3.1-37(a)		and written instructions to CNAs, including care plan changes and written instructions to CNAs that relate to transfers. Results will be presented at the Quality Assurance meeting for three months for evaluation and recommendations. Continuation of audits will be dependent on audit outcomes.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #28 was assessed by her MD and found to have no serious injury related to this deficient practice The resident's care plan was reviewed and updated to include a plan for transfers with extensive assist of one with gait belt and use of hand rails and toilet riser as applicable. Orders for physical and occupational therapy were obtained for Resident #28 to focus on transfers, wheelchair management, and therapeutic activities.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents receiving assistance with transfers have the potential to be affected by this deficient practice. Transfer instructions for each applicable resident will be reviewed and revised as needed by the Director of Nursing or her designee so that they are specific as to number of staff needed to assist. In addition, nursing staff	

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			and rehabilitation staff will work together to assess transfer needs according to resident's preference for assistance; resident's mobility and degree of dependency; resident's size; resident's weight-bearing ability; resident's cognitive status; and whether the resident is usually cooperative with staff. It will then be verified that written instructions to CNAs and the plan of care properly reflect transfer instructions. All CNAs will have a skill verification completed regarding transfer technique and will be trained on how to access resident-specific transfer instructions. This training will be coordinated by the DIrector of Nursing or her designee. The process of communicating and documenting change in plan of care will be discussed in daily stand-up meeting. Changes to a plan of care will be timely and appropriate and, when applicable, will also reflect in written instructions to CNAs. Licensed staff will be inserviced on the comprehensive care planning process. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:Newly hired licensed staff orientation will include training on the comprehensive care planning process. Newly hired CNAs will have a skill verification completed regarding transfer technique and will be trained on how to access	

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			resident-specific transfer instructions. Transfer instructions for each applicable resident will be reviewed and revised as necessary at least quarterly by the interdisciplinary care plan team. The instructions will be specific as to number of staff needed to assist. Nursing staff and rehabilitation staff will work together to assess transfer needs according to resident's preference for assistance; resident's mobility and degree of dependency; resident's size; resident's weight-bearing ability; resident's cognitive status; and whether the resident is usually cooperative with staff.The MDS coordinator will be responsible to assure care plans are audited for accuracy during care plan meetings. The MDS coordinator will also ensure that changes in care routine are reflected in the plan of care. The scheduler will be responsible to ensure that changes in care routine are accurately reflected in written instructions to the CNAs. Resident and/or responsible party and MD involvement in the care plan process will be encouraged. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The MDS nurse and scheduler will audit tranfer assessments, care plan changes and written instructions to CNAs, including care plan changes and written instructions to CNAs that relate to transfers. Results will be	

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			presented at the Quality Assurance meeting for at least three months for evaluation and recommendations. Continuation of audits will be dependent on audit outcomes.	
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the environment remained free of accident hazards i.e. following manufacturer's guidelines and/or sharp objects e.g. knife out of reach for 2 of 2 residents transferred by mechanical lift and/or cognitively impaired with independent ambulation in a sample of 15 and 1 of 1 residents transferred by mechanical lift in a supplemental sample of 7. [Resident #20, Resident #43, Resident #59] Findings include: 1. On 5/24/11 at 2:35 p.m., Resident #43 was observed to be transferred by CNA #1 and CNA #2 utilizing the "Maxi Move" mechanical lift. The resident was transferred from the bed to the wheelchair. The resident was observed to be lifted 18 inches off of the mattress and did not face the mast. The resident was lifted in the highest position on the mast. The staff positioned the wheelchair	F0323	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Residents #43 and #20 suffered no adverse effect from this deficient practice. Resident #59 was not injured as a result of the incident.A physican order for the Maxi Move mechanical lift was obtained for resident #43 and the care plan for transfer was revised to be specific and appropriate. Written instructions to the CNAs for resident #43 to be transferred were revised to reflect the plan of care. A physician order for the Temp mechanical lift was obtained for resident #20 and the care plan for transfer was revised to be specific and appropriate. Written instructions to the CNAs for resident #20 for transfer was revised to be specific and appropriate. Training with return demonstration was conducted for CNAs regarding how to properly use the Maxi Move mechancial lift and the Tempo mechanical lift. Resident #59's psychologist was contacted to provide consultation	06/29/2011

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	sideways (parallel) and the resident was transferred over the side of the wheelchair. The tipper bars of the wheelchair were observed to "catch" on the legs of the lift as the wheelchair was moved away from the lift. Review of the clinical record of Resident #43 on 5/27/11 at 2:45 p.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 4/20/11. The assessment identified the resident as requiring total care for transfers. The CNA assignment sheet for Resident #43 indicated the resident was transferred utilizing the lift. 2. On 5/25/11 at 6:30 a.m., Resident #20 was observed to be transferred from the bed to the chair utilizing the "Tempo" mechanical lift by CNAs #4 and #5. The resident was observed to be lifted 18 inches off of the surface of the mattress. The resident was raised to the highest position on the mast. The base of the lift was opened after the resident was in the lift. The lift was then moved while the resident remained in the high position. The CNAs were observed to tip the wheelchair up off of the floor and then lower the resident into the seat of the wheelchair. The wheelchair was then lowered after the resident was positioned into the seat of the wheelchair.		and recommendation to the resident and his MD. Resident #59's plan of care was updated. Lesiure service staff was inserviced on assuring safety in the leisure service kitchen area on the second floor. Training content included ensuring that drawers are always locked when not in use and that the kitchen area is safe and secure at all times, including when staff is not present. A process to verify safety and security of the area at daily assigned intervals was implemented.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents being transferred by mechanical lift have the potential to be affected by this deficient practice. All health center CNAs will be retrained with return demonstration regarding proper use of the Maxi Move mechanical lift and the Tempo mechanical lift. Nursing management will do at least two observations on each shift at least two times per week for at least 4 weeks of CNAs completing transfers by mechanical lift. Deficient observations will be addressed through immediate retraining and counseling.Residents using the Maxi Move mechanical lift or the Tempo mechanical lift will have a physician order stating the specific type mechanical lift to be used in event of transfer. The	

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	On 5/25/11 at 1:15 p.m., Resident #20 was observed to be transferred from the wheelchair to the bed utilizing the "Tempo" mechanical lift by CNAs #6 and #7. The resident was lifted to a position higher than chair seat level from the wheelchair. The resident was moved to the bed in the lift and the resident did not face the mast of the lift. The resident was observed to remain in the high position and to be 8 inches off of the surface of the mattress. Review of the clinical record of Resident #20 on 5/31/11 at 1:30 p.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 4/25/11. The assessment identified the resident as requiring total care for transfers. The CNA assignment sheet for Resident #20 identified the resident as requiring lift for transfers. Review of the manufacturer's guidelines for the "Maxi Move" mechanical lift on 5/26/11 at 4:05 p.m. indicated "...Always transfer patients with the chassis legs in the closed position...Before transferring, position the patient to the face the attendant at approximately the height of a normal chair. This provides a measure of confidence and dignity to the patient..."		resident plan of care will be updated to reflect this specific order. The written instructions to CNAs regarding transfer by mechanical lift will be reflective of the physician order and care plan. The care plan will be reviewed at least quarterly for appropriateness. All residents using the leisure service kitchen area on the second floor have the potential to be affected by this deficient practice. Leisure service staff is aware of their responsibility to assure that the kitchen drawers are locked when not in use and that the kitchen area is secure and safe at all times, including when staff is not present. Safety checks of the second floor leisure service kitchen area are conducted at daily assigned intervals. The Leisure Service Director or her designee will conduct at least daily safety checks of the second floor leisure service kitchen area for at least 4 weeks to assure compliance. Deficient observations will be addressed through immediate retraining and counseling.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:Newly hired CNAs will have a skill verfication completed regarding proper transfer technique with the Maxi Move mechanical lift and the Tempo mechanical lift. Nursing staff and rehabilitation staff will work	

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	Review of the manufacturer's guidelines for the "Tempo" mechanical lift on 5/26/11 at 4:05 p.m. indicated "...Always transport the chassis legs in the narrow (closed) position...Transport the Tempo with the chassis legs on the parallel (closed) position only...Before transportation, turn the patient to face the attendant at approximately normal chair height (see Fig. 14). This gives confidence and dignity and also improves the mobility of the Tempo..."		together to assess transfer needs for residents requiring a mechanical lift on an ongoing basis to determine which type lift is most appropriate and this determination will be made according to resident's preference for assistance; resident's mobility and degree of dependency; resident's size; resident's weight-bearing ability; resident's cognitive status; and whether the resident is usually cooperative with staff. The MDS nurse will be responsible to see that mechanical lift care plans are specifc and appropriate and supported by a physician order. Mechanical lift care plans will reviewed at least quarterly. The scheduler will be responsible to see that CNA written instructions regarding mechanical lifts are specific and reflective of the care plan.Newly hired leisure service staff orientation will include training regarding leisure service's responsiblity to ensure that drawers in the leisure service kitchen area on the second floor are locked when not in use and that the kitchen area is safe and secure at atll times, including when staff is not present. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The Director of Nursing or her designee will audit to verify that residents being transferred by mechancial lift have a specific physician order as well as specific	

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	3. During initial tour on 5/23/11 at 11:50 a.m., with the Minimum Data Set [MDS] coordinator, Resident #59 was identified as having Alzheimer's disease, decreased cognition, transferred with assistance and non-ambulatory. Resident #59's clinical record was reviewed on 5/24/11 at 11:25 a.m. The Minimum Data Set [MDS] assessment, completed on 4/19/11 coded the resident with minimal assistance of one for ambulation, utilized a wheelchair for mobility. The assessment indicated the resident had the physical behavioral symptoms directed towards others one to three days out of seven during assessment period.		transfer care plans and specific written instructions to CNAs. Results will be presented at the Quality Assurance meeting for at least 3 months. Continuation of audits will be dependent on audit outcomes.The Leisure Services Director or her designee will audit to verify the second floor leisure service kitchen is secure and safe at all times, including when staff is not present and that drawers are locked when not in use. Results will be presented at the Quality Assurance meeting for at least 3 monhts. Continuation of audits will be dependent on audit outcomes.	

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	Documentation in a psychologist progress note, dated 1/18/11 indicated the resident had history of depression, agitation, paranoid ideation and received anti-psychotic medication. A nursing note dated 1/12/11 indicated the resident hitting his roommate in the head with a cane that the roommate had made and given him. A nursing note dated 3/23/11 at 1:30 p.m. indicated the resident threw water on his roommate as he thought he was on fire. The physician was notified and increased the resident's medication Zyprexa [antipsychotic.] A nursing note, dated 5/13/11 at 9:30 p.m. indicated staff found resident with sharp knife in his chair. Took knife found in activity area that was left out. A statement, written by CNA #25 on 5/26/11 was provided by the Administrator on 5/27/11 at 4:05 p.m. The statement by the CNA documented: "On May 13th 2011 the emergency light in the activitie room [sic] and I we [sic] to respond and found [name] Resident #59, standing up in the kitchenette area with a black handled steak knife so I took it away from him and put it behind the nurses station. After I went through the			

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	rest of the drawrs [sic] to make sure there was no other knives." On 5/24/11 at 4:30 p.m. the Administrator, DON and MDS Coordinator were interviewed. The staff indicated they had not been made aware of the incident. The Leisure Services Director was interviewed on 5/25/11 at 2:00 p.m. The staff member indicated the drawers in the second floor kitchenette area are to be kept locked. The Director indicated she believed the drawers had been cleaned out that day, and had not all been locked. The Director indicated knives are usually kept up higher in a locked cabinet. The director provided a form titled "Temperature Log," which documented daily refrigerator temperature checks. The Director indicated the form also was to indicate other areas of the area were kept clean, outdated magazines removed, and cabinets locked. 3.1-45(a)(1)			

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F0334 SS=B	The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes			

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	documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on record review and interview, the facility failed to ensure each residents' medical record included documentation of the resident or residents' legal representative being provided information regarding the benefits and potential side effects of the influenza and/or pneumococcal immunizations for 5 of 15 residents identified receiving or offered the influenza and/or pneumococcal immunizations in a sample of 15. (Resident #42, Resident #48, Resident # 28, Resident # 32 , Resident # 25) Findings include: 1. Review of the clinical record of Resident #42 on 5/27/11 at 5:30 p.m.	F0334	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Residents #48, #42, #28, #32, and #25 have not had any adverse effects from the deficient practice. They and/or their responsible parties have now all received information regarding the benefits and potential side effects of the influenza and pneumococcal vaccinations. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents have the potential to be affected by this deficient practice. All residents and/or their responsible parties will receive information in writing regarding the risks and benefits	06/29/2011

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	indicated the resident received the influenza immunization on 10/30/10. Documentation of the resident being made aware of the benefits and potential side effects of the influenza immunization/pneumococcal immunization was lacking. 2. Review of the clinical record of Resident # 48 on 5/25/11 at 1:05 p.m. indicated the resident received the influenza immunization on 10/30/10. Documentation of the resident being made aware of the benefits and potential side effects of the influenza immunization/pneumococcal was lacking.		of the influenza and pneumococcal vaccines prior to signing the consent for administration or the declination of administration forms.All nurses will be inserviced regarding the proper sequence of presenting the form prior to administration or declination and of the proper use of the consent form.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:The consent for administration/declination of administration of the influenza and pneumococcal vaccines will include the wording that the information regarding the risks and benefits of the vaccines from the CDC has been provided to the resident and/or their responsible party in writing. The Medical Records Coordinator will ensure that new and correctly worded consent forms are placed in admission packets and that they are available at the nurses' stations.Proper completion of the form for new admissions will be verified by the Medical Records Coordinator at daily stand-up meeting for at least 4 weeks. Deficient outcomes will be addressed immediately and will include retraining and counseling.All newly hired nurse orientations will include training regarding the proper sequence of presenting the form prior to administration or declination and	

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			of the proper use of the consent form.How the corrective action(s) will be monitored to ensure the deficient practice does not recur:The Director of Nursing or her designee will audit for compliance. Results will be presented at the Quality Assurance meeting for at least three months for evaluation and recommendations. Continuation of audits will be dependent on audit outcomes.	
	3. Resident #28's clinical record was reviewed on 5/25/11 at 12:05 p.m. An admission date was noted of, 5/6/08. Documentation indicated the resident received a influenza vaccine on 11/1/10. Documentation to indicate the resident and/or resident's family had been educated regarding potential side effects and the benefits concerning immunization was lacking. 4. Resident #32's clinical record was reviewed on 5/26/11 at 3:05 p.m. An admission date was noted of 4/29/10. Documentation indicated the resident received a influenza vaccine on 10/26/10. Documentation to indicate the resident and/or resident family had been educated regarding the potential side effects and the benefits concerning immunization was lacking. 5. Resident #25's clinical record was reviewed on 5/26/11 at 9:45 a.m. An admission date was noted of 1/28/11. The most recent Minimum Data Set (MDS) assessment dated 2/10/11 did not identify the resident as receiving the			

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	influenza/pneumococcal vaccinations as a "dash" was documented. Documentation of the vaccination education information regarding benefits and potential risks being provided to the resident or resident's legal representative was lacking. Review of the facility's current policy and procedure titled "Influenza Vaccine" dated 12/07 on 5/31/11 at 2:30 p.m. indicated "...4. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine...Provision of such education shall be documented in the resident's/employee's medical record..." Review of the facility's current policy and procedure titled "Pneumococcal Vaccine" dated 12/07 on 5/31/11 at 2:30 p.m. indicated "...3. Before receiving the Pneumovax, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine...Provision of such education shall be documented in the resident's medical record..." Interview of the Director of Nursing on 5/31/11 at 11:35 a.m. indicated benefits of the influenza and pneumococcal vaccines			

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	were not kept on the medical records of residents. The DON indicated the information was provided to the resident and/or legal representative upon admission. 3.1-13(a)			
F0368 SS=C	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on interview and record review, the facility failed to ensure bedtime snacks were offered daily for 20 of 20 residents present in group meeting. [Residents #2, #4, #9, #10, #18, #19, #20, #21, #23, #24, #27, #31, #32, #34, #35, #41, #42, #43, #50, #56] Findings include:	F0368	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Residents #2, #4, #9, #10, #18, #19, #20, #21, #23, #24, #27, #31, #32, #34, #35, #41, #42, #50, and #56 have not experienced any adverse effects from the deficient practice.How other residents have the potential to be affected by the same deficient practice will be identified and what corrective	06/29/2011

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	1. During group meeting on 5/24/11 at 10 a.m., 20 of 20 residents [Residents #2, #4, #9, #10, #18, #19, #20, #21, #23, #24, #27, #31, #32, #34, #35, #41, #42, #43, #50, #56] indicated snacks were not offered on a daily basis at bedtime. The residents indicated snacks were provided only if they were requested. During interview on 5/24/11 at 9:55 a.m., Leisure staff person #1 indicated the residents in the group meeting were interviewable. During interview on 5/27/11 at 3:50 p.m., CNA #22 indicated dietary delivers the snacks for bedtime and leaves them at the nursing station. The CNA also indicated that if residents requested a snack then the snack would be provided. The CNA indicated the nursing staff did not offer snacks to all residents nightly. Review of the policy and procedure titled "Hydration Cart Policy and Procedure" [no date] on 5/31/11 at 1:20 p.m. indicated "...5. Snacks and beverages will be provided from the hydration cart at 7 p.m. and at the 2 p.m. hydration cart pass..." 3.1-21(e)		action(s) will be taken:All residents have the potential to be affected by the deficient practice. All health center nursing staff have been trained regarding their responsibility to ensure that all residents are offered a snack at bedtime, unless medically contraindicated, regardless of their asking for or their ability to ask for a snack. The offering and acceptance of bedtime snacks will be documented by CNAs and this form will be reviewed by the Director of Nursing or her designee.10 or more random and targeted interviews and observations by mangement will occur weekly for at least 4 weeks to ensure that bedtime snacks are being offered to all residents, unless medically contraindicated, regardless of their asking for or their ability to ask for a snack.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:All newly hired nursing staff will be informed during orientation of their responsiblity to ensure that all residents are offered a snack at bedtime, unless medically contraindicated, regardless of their asking for or their ability to ask for a snack.Resident council officers will be asked to include bedtime snacks being offered as a topic for at least 3 months. In addition, resident satisfaction interviews will include whether or not	

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			bedtime snacks are being offered. Negative responses will be reported to the administrator immediately and will result in retraining and counseling. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur:The Director of Nursing or her designee will audit records related to the offering and acceptance of bedtime snacks. Results will be presented at the Quality Assurance meeting for at least three months for evaluation and recommendations. Continuation of audits will be dependent on audit outcomes.	
F0387 SS=D	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on interview and record review, the facility failed to ensure 1 of 15 residents in a sample of 15 were seen by the physician at least once every 30 days for the first 90 days after admission. [Resident #25] Finding includes: Resident #25's clinical record was reviewed on 5/26/11 at 9:45 a.m. An admission date was noted of 1/28/11. The only physician's progress note on the	F0387	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #25 had no adverse effect from this deficient practice. Resident has now been seen by her physician and a physician progress note was completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents who do not have the Medical Director for their	06/29/2011

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	record was dated 3/30/11. The Medical Records Director was interviewed on 5/26/11 at 10:50 a.m. The staff member indicated the physician had been notified by the facility of the need for physician visits, but the resident had only be seen one time since admission. The staff member indicated the family was aware of the need for the resident to be seen by the physician, but refused to let the resident be seen by the Medical Director. Review of the facility's current policy and procedure titled "Physician Services" dated 8/06 on 5/31/11 at 2:30 p.m. indicated "...4. Physician visits, frequency of visits, emergency care of residents, etc. are provided in accordance with current OBRA regulations and facility policy..." 3.1-22(d)(1)		attending MD have the potential to be affected by this deficient practice. The Medical Records Coordinator will keep a current log of attending MD visits for each resident. Attending MD will be notified by phone and in writing when a resident is within 7 days of not meeting State and community guidelines for physician visit timeliness. The Medical Records Coordinator will notify the Medical Director if the attending MD fails to comply. The Medical Directior will then see the resident and complete a progress note within 72 hours of notification.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:The Medical Records Coordinator will keep a current log of attending MD visits for each resident. The resident and/or their responsible party will be notified in writing by the community when the resident is within 7 days of not meeting State and community guidelines for physician visit timeliness. A copy of the notification will go to the attending MD along with his or her own written notification. The resident and/or their responsible party will also be notified by the community in writing when/if the Medical Director must see the resident and make a progress note to maintain or re-establish physician visit timeliness. How the corrective action(s) will be	

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			monitored to ensure the deficient practice does not recur:The Medical Records Coordinator will audit physician visit timeliness and Medical Director intevention to maintain or re-establish physician visit timeliness. Results will be presented at Quality Assurance meetings for at least three months for evaluation and recommendations. Continuation of audits will be dependent on audit outcomes.	

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to 1) ensure staff practiced proper hand hygiene while providing care for 2 of 5 residents observed receiving incontinence care in a	F0441	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #46 is no longer at the facility. Residents #43, #19, #20, #22,	06/30/2011

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	sample of 15 and 3 of 5 residents observed receiving incontinence care and/or personal hygiene in a supplemental sample of 7 and 2) ensure staff followed contact isolation precautions for 1 of 1 residents identified utilizing contact isolation precautions in sample of 15. [Residents #43, #19, #20, #22, #1, #46] [CNAs #1, #3, #7, RN #17] Findings include: 1. On 5/24/11 at 2:35 p.m., Resident # 43 was observed to receive incontinence care by CNAs #1 and #2. CNA #1 with gloves on was observed to provide pericare to resident. Without changing the contaminated gloves, CNA #1 reached into bedside table drawer, picked up disposable wipes, utilized the wipes, and applied a new attends. The CNA then removed the contaminated gloves. 2. On 5/25/11 at 4:35 a.m., Resident #19 was observed to receive personal hygiene by CNA #3. CNA #3, with gloves on, washed the resident's face and torso. The CNA was then observed to remove gloves and wipe her nose with tissue. The CNA then placed her hands in the bath water and continued to dress the resident. The CNA did not apply new gloves. 3. On 5/25/11 at 4:50 a.m., Resident # 20		and #1 did not experience any adverse effects from the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents have the potential to be affected by the deficient practice(s). All CNAs will receive training and skills verification check for peri care.All CNAs will receive training and skills verfication check for incontinence care.All nursing staff will receive training on glove use and changing gloves. All staff will receive training on contact isolation precautions.All staff will receive training on Standard Precautions and that Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. All staff will receive training regarding Handwashing and this training will include informing that employees must wash thier hands for at least fifteen seconds using antimicrobial soap or non-antimicrobial soap and water under the following conditions: before and after direct resident contact; before and after assisting a resident with personal care; upon and after coming in contact with a resident's intact skin such as when taking a pulse; after blowing or wiping nose; after contact with a resident's mucous	

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	was observed to receive incontinence care by CNA #3. The resident was observed to be incontinent of urine and bowel. Without changing the contaminated gloves, the CNA applied a new attends on the resident. The CNA then removed the gloves and applied the resident's bilateral knee hi elastic hose. 4. On 5/25/11 at 5:10 a.m., Resident # 22 was observed to receive incontinence care by CNA #3. The resident was observed to be incontinent of urine. Without changing the contaminated gloves, the CNA was observed to apply a new attends.		membranes and body fluids or excretions. The Director of Nursing or her designee will make or assign infection control rounds daily. Time of day will vary and each shift will receive 2 or more infection control rounds per week. These rounds will include observation of staff practice in regards to peri care, incontinence care, glove use, changing gloves, and Standard Precautions compliance as well as contact isolation procedures when applicable. Deficient practices will be addressed immediately through training and counseling. A rounding tool will be used to document round results and responses.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:Infection control will be an all-staff training topic at least every six months.New hire orientation for CNAs will include training and skills verification for peri care and incontinence care.New hire orientation for all nursing staff will include training on glove use and changing gloves.New hire orientation for all staff will include training on contact isolation procedures, Standard Precautions, and handwashing.Nursing management will conduct daily infection control rounds using a rounding tool. Deficient practices will be addressed immediately through training and	

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	155221	A. BUILDING 00 B. WING	05/31/2011

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	5. On 5/25/11 at 10:25 a.m., Resident #1 was observed to receive care. CNA #7 removed urine soaked incontinence briefs and slacks from the resident. Without changing gloves, the CNA assisted RN #17 to place a clean incontinence brief and slacks. RN #17, after cleansing urine from the resident's skin and without changing gloves, the RN pulled up the resident's clean brief and slacks. Review of the facility's current policy and procedure titled " Handwashing/Hand Hygiene" dated 4/2010 on 5/26/11 at 4:10 p.m. indicated "...Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice.); ...h. Before and		counseling.How the corrective action(s) will be monitored to ensure the deficient practice does not recur:The Director of Nursing or her designee will audit infection control training and rounds. Results will be presented at Quality Assurance meetings for at least three months for evaluation and recommendations. Continuation of audits will be dependent on audit outcomes.	

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	after assisting a resident with personal care (e.g. oral care, bathing.) ; ...l. Upon and after coming in contact with a resident's intact skin, (e.g. when taking a pulse or blood pressure, and lifting a resident); ...p. After blowing or wiping nose; q. After contact with a resident's mucous membranes and body fluids or excretions;..." 6. On 5/23/11 at 11:45 a.m. during initial tour, CNA #7 was observed to enter Resident # 46's room to provide care to the resident. The CNA was observed to enter the room without donning a gown. A contact isolation table was observed outside of the resident's room. Interview of the MDS coordinator on tour 5/23/11 at 11:45 a.m. indicated Resident #46 was in contact isolation precautions due to a recent diagnosis of Clostridium Difficile. Interview of CNA #23 on 5/26/11 at 11:20 a.m. indicated the resident was removed from precautions 5/24/11. However, when CNA #23 was assigned to care for resident during contact isolation precautions, the staff wore gloves to care for the resident and roommate. CNA #23 indicated they disposed of gloves used for resident and soiled linens in containers in the resident's room. The use of gowns			

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	while caring for Resident # 46 was not indicated. Interview of Resident #46's family on 5/24/11 at 11:35 a.m. indicated the staff did not wear gowns when assisting the resident to the bathroom or providing incontinence care for the resident. Review of facility's current policy and procedure titled "Healthcare-Associated Infections, Identifying" dated 12/2007 on 5/26/11 at 4:10 p.m. indicated "...Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status....d. Gown (1) In addition to wearing a gown as outlined under Standard Precautions, wear a gown (clean, non sterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. Remove the gown and perform hand hygiene before leaving the resident's environment..." 3.1-18(l) Interview of Resident #46's family on 5/24/11 at 11:35 a.m. indicated the staff did not wear gowns when assisting the resident to the bathroom or providing incontinence care for the resident.			

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R0000				
	The following state residential findings were cited in accordance with 410 IAC 16.2-5.	R0000	By submitting this document we are not admitting the truth or accuracy of any specific findings or allegations. This submission is made solely pursuant to our regulatory obligations.	

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R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to inform the Administrator and report to the Department of Health within twenty-four hours 1 of 1 occurrence of resident elopement in a sample of 4. Finding includes: On 5/25/11 at 2:15 p.m. the Administrator provided a form titled "Facility Incident Reporting Form," which documented an incident that occurred 2/10/11 at 1:50 a.m. The report included documentation of Resident #4 leaving her apartment and went outside and stood on sidewalk near entrance under the canopy without telling staff. The date on the report form of the Department of Health being notified was noted of March 9, 2011. A report of an investigation of the incident, provided by the MDS [Minimum Data Set] Coordinator on 5/25/11 at 2:15 p.m. included, but was not limited to : "2/10/11 at 1:50 a.m. confused resident. Found outside by Security Guard, under 2nd canopy waved at him. Was dressed and had light jacket on (3 degrees) outside. Security said she didn't make sense-something about her car, gave him some "keys" and he called nurse on radio. They were not car keys-she thought they were-she could not get back in building." Two reports of Counseling/Disciplinary Actions, dated 3/8/11 and 3/9/11, completed by the Administrator, and provided by the DON on 5/27/11 at 4:15 p.m. indicated LPN #26 received a	R0090	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #4 suffered no injury as a result of the incident. Family and MD were notified. MD ordered lab work; routine ambien order was changed to administer as needed, frequent checks initiated.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:All residents with mild or greater mental confusion and/or impairment are at risk to be affected by this deficient practice.All staff will be trained on the State and community requirement that the Administrator be informed immediately of resident elopement and that the Department of Health be notified by the Administrator or his designee within 24 hours of the elopement occurring.Daily stand-up will include review of incidents and unusual occurrences, including elopements.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does	05/31/2011

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	written warning for not reporting to the DON during the night shift the resident being found outside and the DON was found in violation of the facility rules in that the Administrator was not made aware of the occurrence until 3/8/11. Interview of the Administrator on 5/25/11 at 2:30 p.m. indicated he was unaware of the elopement until 3/9/11. Review of facility's current policy and procedure titled "Reportable Unusual Occurrences" dated 1/25/2006 on indicated "the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency...ABUSE- physical, sexual, verbal and/or mental (known and/or alleged) ...Resident Elopement- a cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown, Any circumstance of elopement which required police notification..."		not recur:New hire orientation will include training that the State and community requires that the Administrator be informed immediately of resident elopement and that the Department of Health be notified by the Administrator or his designee within 24 hours of elopement occurring.Daily stand-up meeting will include review of incidents and unusual occurrences, including elopements.The administrator or his designee will monitor for events that meet State reportable criteria and will address any non-compliance immediately with training and counseling that may include termination.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The Administrator will audit events reportable to State, including elopements. Results will be reported at the Quality Assurance meeting for at least three months. Continuation of audits will be dependent on audit outcomes.	